MDR Tracking Number: M5-04-1207-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution –General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-23-03.

The IRO reviewed myofascial release, neuromuscular re-education, electric stimulation, therapeutic procedure, hot/cold packs, and vasopneumatic device rendered from 6-30-03 through 7-29-03 that were denied based upon "V".

The IRO concluded that myofascial release, neuromuscular re-education, electric stimulation, therapeutic procedure, hot/cold packs from 7-23-03 through 7-29-03 were not medically necessary. The IRO also concluded that vasopneumatic device rendered from 6-30-03 through 7-29-03 were not medically necessary. The IRO concluded that myofascial release, neuromuscular re-education, electric stimulation, therapeutic procedure, hot/cold packs rendered from 6-30-03 through 7-22-03 were medically necessary.

The Medical Review Division has reviewed the IRO decision. The IRO has not clearly determined the prevailing party over the medical necessity issues. Therefore, in accordance with §133.308(q)(2)(C), the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

DOS	CPT CODE	Billed	MAR$ (Maximum Allowable Reimbursement)	Medically Necessary	Not Medically Necessary
6-30-03 7-1-03 7-3-03 7-7-03 7-8-03	97250	$45.00	$43.00	$43.00 X 5 dates = $215.00	
6-30-03 7-1-03 7-3-03 7-7-03 7-8-03	97112	$40.25	$35.00 / 15 min	$35.00 X 5 dates = $175.00	
6-30-03	97110	$40.25	$35.00 / 15 min	$35.00	
7-1-03	97110 (3)	$40.25 X 3 = $120.75	$35.00 / 15 min X 3 = $105.00	$105.00	
7-3-03 7-7-03 7-8-03 7-14-	97110 (4)	$40.25 X 4 = $161.00	$35.00 / 15 min X 4 = $140.00	$140.00 X 5 = $700.00	

03 7-15- 03					
6-30- 03	97014	$17.25	$15.00	$15.00	
7-1-03	97010	$12.05	$11.00	$11.00	
7-3-03 7-7-03 7-8-03	97016	$27.60	$24.00		$24.00 X 3 dates = $72.00
7-29- 03	97110 (3)	$40.25 X 3 = $120.75	$35.00 / 15 min X 3 = $105.00		$105.00
TOTAL				$1256.00	177.00

Consequently, the commission has determined that **the requestor prevailed** on the majority of the medical fees ($1256.00). Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 21, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

No EOB: Neither party in the dispute submitted EOBs for some of the disputed services identified above. Since the insurance carrier did not raise the issue in their response that they had not had the opportunity to audit these bills and did not submit copies of the EOBs, the Medical Review Division will review these services per *Medical Fee Guideline*.

DOS	**CPT CODE**	**Billed**	**Paid**	**EOB Denial Code**	**MAR$ (Maximum Allowable Reimbursement)**	**Reference**	**Rationale**
5-27- 03 5-28- 03 6-6-03 6-24- 03	97250	$45.00	$0.00	No EOB	$43.00	CPT Code Descriptor MAR	MAR reimbursement of $43.00 X 4 dates = $172.00 is recommended.
5-27- 03 5-28- 03	97112	$40.25	$0.00	No EOB	$35.00 / 15 min	CPT Code Descriptor MAR	MAR reimbursement of $35.00 X 5 dates = $175.00 is recommended.

5-29-03 6-6-03 6-24-03							
5-27-03 5-28-03 5-29-03 6-24-03	97014	$17.25	$0.00	No EOB	$15.00	CPT Code Descriptor MAR	MAR reimbursement of $15.00 X 4 dates = $60.00 is recommended.
5-27-03 5-28-03 5-29-03 6-6-03	97016	$27.60	$0.00	No EOB	$24.00	CPT Code Descriptor MAR	MAR reimbursement of $24.00 X 4 dates = $96.00 is recommended.
5-29-03	97140	$50.00	$0.00	No EOB	Unrecognized Code	Rule 134.201.	No reimbursement is recommended unrecognized code.
6-6-03 6-16-03 6-17-03	97032	$25.30	$0.00	No EOB	$22.00 / 15 min	CPT Code Descriptor MAR	MAR reimbursement of $22.00 X 3 dates = $66.00 is recommended.
6-16-03 6-17-03	97010	$12.65	$0.00	No EOB	$11.00	CPT Code Descriptor MAR	MAR reimbursement of $11.00 X 2 dates = $22.00 is recommended.
6-6-03	99204	$121.90	$0.00	No EOB	$71.00	CPT Code Descriptor MAR	MAR reimbursement of $71.00 is recommended.
7-9-03 7-21-03	97110 (4)	$40.25 X 4 = $161.00	$0.00	No EOB	$35.00 / 15 min X 4 = $140.00	CPT Code Descriptor	See Rationale Below
7-17-03	97110 (2)	$40.25 X 2 = $80.50	$0.00	No EOB	$35.00 / 15 min X 2 = $70.00		
6-16-03 6-17-03 6-24-03 7-28-03	97110 (3)	$40.25 X 3 = $120.75	$0.00	No EOB	$35.00 / 15 min X 3 = $105.00		
7-22-03	99213	$55.00	$0.00	No EOB	$48.00		MAR reimbursement of $48.00 is recommended.

8-6-03	97110 (4)	$50.00 X 4 = $200.00	$0.00	No EOB	$35.90 / 15 min X 4 = $143.60		See Rationale Below
TOTAL							The requestor is entitled to reimbursement of **$710.00.**

Rationale for 97110:

Recent review of disputes involving one-on-one CPT code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on –one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The therapy notes for these dates of service do not support any clinical (mental or physical) reason as to why the patient could not have performed these exercises in a group setting, with supervision, as opposed to one-to-one therapy. The Requestor has failed to submit documentation to support reimbursement in accordance with the 1996 MFG and Rule 134.202 and 133.307(g)(3). Therefore, reimbursement is not recommended.

This Decision is hereby issued this 15th day of September, 2004

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

ORDER.

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Decision is applicable for dates of service 5-27-03 through 8-6-03 in this dispute.

This Order is hereby issued this 15th day of September , 2004.

Roy Lewis
Medical Dispute Resolution Supervisor
Medical Review Division

Enclosure: IRO Decision

April 15, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1207-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ------ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified in physical medicine and rehabilitation. The ------ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 37 year-old female who sustained a work related injury on ------. The patient reported that while at work, she injured her back. The patient underwent back x-rays that were reported to be normal. The patient underwent a MRI of the lumbar spine on 7/8/03 that showed a 2-3mm bulge at the L5-S1 level with out nerve root compression. The patient has been treated with physical therapy, medication, myofascial release, neuromuscular reeducation, electrical stimulation, and a vasopneumatic device. The patient also had a work related neck injury and was receiving physical therapy for neck and back injury.

Requested Services

Myofascial release, neuromuscular reeducation, electrical stimulation, therapy procedure, hot/cold pack, and vasopneumatic device from 6/30/03 through 7/29/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ physician reviewer noted that this case concerns a 37 year-old female who sustained a work related injury to her neck and back on ------. The ------ physician reviewer indicated that the patient received physical therapy beginning 6/3/03. The ------ physician reviewer noted that initially the patient had decreased cervical, lumbar and sacral spine range of motion, decreased sitting tolerance, and pain rated at a 6-7/10. The ------ physician reviewer also noted that by 7/22/03 the patient had achieved normal cervical range of motion, near normal/functional range of motion in her lumbar spine, and her sitting tolerance had increased to >1hour. The ------ physician reviewer further noted that the patient had been independent in a home exercise program since mid June and had returned to modified duty work on 7/5/03. The ------ physician reviewer explained that the patient's pain level had remained unchanged and that a MRI dated 7/8/03 revealed a L5 disc bulge. The ------ physician reviewer indicated that there are several notes from physical therapy documenting how well this patient was progressing. The ------ physician reviewer explained that the patient did not require supervised physical therapy after 7/22/03 and could have continued with an independent home exercise program with moist heat as needed. Therefore, the ------ physician consultant concluded that the myofascial release, neuromuscular reeducation, electrical stimulation, therapy procedure, and hot/cold pack, from 7/22/03 through 7/29/03 were not medically necessary to treat this patient's condition. The ------ physician consultant also concluded that the vasopneumatic device from 6/30/03 through 7/29/03 were not medically necessary to treat this patient's condition. However, the ------ physician consultant concluded that the myofascial release, neuromuscular reeducation, electrical stimulation, therapy procedure, and hot/cold pack from 6/30/03 through 7/22/03 were medically necessary to treat this patient's condition.

Sincerely,

State Appeals Department